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**MMCD Policy Letter No. 96-13**

- TO:**
- Prepaid Health Plans (PHP)**
  - Primary Care Case Management (PCCM) Plans**
  - County Organized Health Systems (COHS)**
  - Geographic Managed Care (GMC) Plans**

**SUBJECT: IMMUNIZATION SERVICES IN MEDI-CAL MANAGED CARE**

**BACKGROUND**

The purpose of this policy letter is to clarify Medi-Cal Managed Care's (MMCD) requirements for the provision of immunizations to children, which is an essential component of the comprehensive periodic health assessments required for Medi-Cal members under age 21 (see MMCD Policy Letter No. 96-12, Pediatric Preventive Services). In addition, this policy letter clarifies requirements for out-of-plan reimbursement of immunization services to Local Health Departments (LHDs).

**GOALS**

- 1) To ensure that all Medi-Cal managed care members are maximally protected against vaccine-preventable diseases by facilitating access to immunization services and reducing missed opportunities to immunize.
- 2) To ensure effective immunization delivery and control of vaccine-preventable diseases by establishing cooperative efforts between Medi-Cal Managed Care Plans and LHDs.

## POLICY

### I. Guidelines for the Delivery of Immunization Services

All contracting health Plans (COHS', PHPs, and PCCMs, including those in the GMC and Two-Plan Model and referred to henceforth as the Plans) are required to provide or arrange for immunization services according to the most recent Childhood Immunization Schedule approved by the Advisory Committee on Immunization Practices (ACIP) (see Enclosure I). Updated recommendations of the ACIP are published periodically in the Morbidity and Mortality Weekly Report. All contracting Plans are required to implement procedures to ensure that members have prompt access to immunization services.

Some Plans (e.g., Plans in the Two-Plan Model and GMC programs) are required to execute a subcontract with the LHDs for reimbursement of immunization services when such services are provided to Plan members who are not up to date on their immunization schedule. Plans are not required to reimburse LHD for immunizations already provided by the Plan.

### II. Out-of-Plan Reimbursement to LHDs (Two-Plan Model and GMC Plans)

#### A. Definition of Up-To-Date Immunization Status:

A Medi-Cal member will be considered up to date with regard to immunizations if he/she has received all immunizations for which he/she is eligible based on ACIP recommendations. A member is eligible for an immunization at the earliest age specified by ACIP. LHDs may bill Plans for the administration of any vaccine for which the Medi-Cal member is not up to date (i.e., for which they are eligible) according to the most recent ACIP immunization schedule at the time the member presents to the LHD provider. Vaccines for which the member is found to be not up to date may be administered regardless of the reason for which the member presents to the LHD provider.

#### B. Conditions for Reimbursement of LHDs:

1. The LHD must assess and document the immunization status of the Plan member by obtaining an immunization history from the Plan member, parent, or guardian. If the history is unavailable or is

unreliable, the LHD should attempt, whenever possible, to obtain the immunization information from the Plan or primary care physician (PCP).

2. The LHD must submit claims according to the Plan's specified billing procedures.
3. The LHD must provide medical information sufficient to allow the Plan to meet case management responsibilities.

If all the above conditions are met, Plans must assure the timely reimbursement of the LHDs. For PHPs, including all Two-Plan Model and some GMC Plans, timely reimbursement is defined as payment of a claim within 30 days of receipt of all necessary documentation. If a Plan determines that a claim is incomplete or is to be contested, the Plan must notify the LHD of this fact within 30 days. Other Plans should refer to their contracts for timeliness requirements.

Plans must reimburse LHDs at the approved Medi-Cal fee-for-service rate(s), appropriate for the provider type, as specified in Title 22 CCR, Section 51501 et seq., unless other rates have been negotiated between the Plan and the LHD. LHDs using state supplied vaccine may not bill Plans for the cost of the vaccine itself, but may bill for the vaccine administration fee.

Plans must have a provider claims appeal system pursuant to the following requirements: Title 22, CCR, Section 56262 for PCCMs; Health and Safety Code Section 1370.2 for PHPs; and provisions of COHS contracts. In the event of disputes, Plans must advise LHDs in writing of the process for mediating claim disputes.

If the Plan member has consented to the release of information to the PCP, the medical documentation must be forwarded to the PCP. Plans must implement procedures to facilitate the PCP's timely provision of all needed follow-up care. The Plans, as well as the LHDs, must educate Plan members regarding the significant positive impact of coordinated care on clinical outcomes, the problems associated with fragmentation of care, and the importance of allowing medical information to be shared between providers.

### III. Assessment of Immunization Rates

As a component of the internal quality improvement program, some Plans (Two-Plan Model and GMC Plans) are required to assess immunization rates for its members annually and report these rates to MMCD. Other Plans are strongly encouraged to do the same. In order to assure comparability over time and across Plans, the Plans must utilize Medicaid HEDIS specifications for this assessment. Plans should target quality improvement program interventions to attain, at a minimum, the Healthy People 2000 Objective: completion of basic immunization series by 90 percent of two-year old children by the year 2000.

Plans that are capitated for immunization services are required to report these services on the PM160 INFORMATION ONLY form. Plans must submit completed forms to the Department of Health Services and the local Child Health and Disability Program (CHDP) no later than 30 days following the end of each month in which the encounter occurs. Plans whose contracts do not include immunization services must use the PM160 BILLING form, if the Plan providers are CHDP certified. In counties where the immunization registry is implemented, Plans are expected to participate in this registry to facilitate data collection and tracking of immunizations for all preschool age children (see Enclosure II).

### IV. Health Education and Outreach

Plans must implement procedures for notifying members in writing of the recommended schedule for immunizations and the availability of immunization services and for conducting outreach to members who are not up to date for their immunizations. Plans are expected to issue reminder interventions (i.e., postcards, letters, etc.) to prompt patients to come in for needed immunizations. All correspondence must be written at the appropriate literacy level (4th - 6th grades) and should be available in the appropriate languages for the service area. Plans are encouraged to participate in LHDs' public education campaigns regarding immunizations.

### V. Provider and Staff Education

Plans are responsible for assuring that appropriate immunization information and training is available to their providers. Plans may request LHDs to provide technical assistance, training, and material related to immunizations to the Plan's providers.

**VI. Reporting of Vaccine-Preventable Diseases**

Plans will assist LHDs in educating Plan providers (including medical laboratories affiliated with the Plans) about their responsibilities to report vaccine-preventable diseases (and other infectious diseases) according to California Health and Safety Code regulations.

Plans will cooperate and assist LHDs in informing affiliated providers of reported disease outbreaks and implementation of control procedures.

**VII. Vaccines for Children's Program**

Plan providers are eligible to participate in the federally funded Vaccines For Children (VFC) Program. The VFC Program provides free vaccine for eligible children (including all children ages 18 years or younger on Medi-Cal) and distributes immunization updates and related information to participating providers. Plans should both encourage their providers to participate in the VFC Program and assist them in enrolling. Plans and providers may obtain more information by contacting the VFC office at (510) 704-3750.

**DISCUSSION:**

LHDs' responsibilities in achieving the goals stated above include, but are not limited to the following:

**1. Provision of Immunization Services to Plan Members**

LHDs must implement procedures to identify Plan members appropriately, and assess and document the immunization status of the Plan member before provision of any immunization services. Plans are not required to reimburse the LHD for immunizations provided to members who are not eligible for the immunization according to the ACIP schedule or for immunizations already provided by the Plan.

**2. Immunization Billing Procedures**

LHDs must implement appropriate billing procedures to comply with all the conditions for reimbursement.

3. Notification of Plan's PCPs of LHD Immunizations

LHD providers will notify Plan's PCPs of immunization services provided to members in a manner mutually agreed upon by the Plan and the LHD in the subcontract. One potential method would be for the LHD provider to fax a copy of the California Immunization Record (yellow card) to the Plan PCP. LHDs will refer up to date Plan members to their Plan PCPs for future immunizations. LHDs will educate Plan members on the importance of obtaining periodic health assessments, including immunizations from their PCPs.

4. Assessment of Immunization Rates

LHDs are responsible for collecting and analyzing data on the overall immunization rate of the county population. LHDs will provide Plans with periodic reports of the county immunization rates as well as rates for specific subgroups of population. LHDs must involve Plans in the planning and development of immunization registries, and if possible, seek compatibility with the existing management information systems of the Plans.

5. Vaccine Preventable Diseases

LHDs are responsible for collecting and analyzing data on vaccine-preventable diseases, investigating disease outbreaks, and conducting epidemiological investigations of vaccine preventable diseases. LHDs will coordinate with the Plans in conducting epidemiological investigations of vaccine preventable disease.

6. Provider and Staff Education

LHDs will assist Plans in training and educating Plan's providers regarding the latest advancement in the field of immunizations, providers' disease reporting responsibilities, and the use of appropriate disease reporting forms.

LHDs, upon request by Plans, are expected to provide technical assistance, training, and materials related to immunizations to the Plans, contingent upon availability.

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7. Health Education and Outreach

LHDs will assist Plans in their outreach efforts by conducting public education campaigns regarding immunizations. LHDs are encouraged to provide Plans with public domain educational materials for their members.

If there are any questions regarding this policy, please contact your Health Plan Manager.

Sincerely,



Joseph A. Kelly, Chief  
Medi-Cal Managed Care Division

Enclosures

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# Recommended Childhood Immunization Schedule United States, July - December 1996

Vaccines are listed under the routinely recommended ages. **Bars** indicate range of acceptable ages for vaccination. **Shaded bars** indicate **catch-up vaccination**: at 11-12 years of age, hepatitis B vaccine should be administered to children not previously vaccinated, and Varicella Zoster Virus vaccine should be administered to children not previously vaccinated who lack a reliable history of chickenpox.

Age Vaccine	Birth	1 mo	2 mos	4 mos	6 mos	12 mos	15 mos	18 mos	4-6 yrs	11-12 yrs	14-16 yrs
Hepatitis B <sup>1,2</sup>	Hep B-1		Hep B-2		Hep B-3					Hep B <sup>3</sup>	
Diphtheria, Tetanus, Pertussis <sup>3</sup>			DTP	DTP	DTP	DTP <sup>3</sup> (DTaP at 15+ m)			DTP or DTaP	Td	
<i>H. influenzae</i> type b <sup>4</sup>			Hib	Hib	Hib <sup>4</sup>	Hib <sup>4</sup>					
Polio <sup>5</sup>			OPV <sup>5</sup>	OPV	OPV				OPV		
Measles, Mumps, Rubella <sup>6</sup>						MMR			MMR <sup>6</sup> or	MMR <sup>6</sup>	
Varicella Zoster Virus Vaccine <sup>7</sup>						Var				Var <sup>7</sup>	

Approved by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP),  
and the American Academy of Family Physicians (AAFP).



- 1 Infants born to HBsAg-negative mothers** should receive 2.5 µg of Merck vaccine (Recombivax HB) or 10 µg of SmithKline Beecham (SB) vaccine (Engerix-B). The 2nd dose should be administered  $\geq 1$  mo after the 1st dose.
- Infants born to HBsAg-positive mothers** should receive 0.5 mL hepatitis B immune globulin (HBIG) within 12 hrs of birth, and either 5 µg of Merck vaccine (Recombivax HB) or 10 µg of SB vaccine (Engerix-B) at a separate site. The 2nd dose is recommended at 1-2 mos of age and the 3rd dose at 6 mos of age.
- Infants born to mothers whose HBsAg status is unknown** should receive either 5 µg of Merck vaccine (Recombivax HB) or 10 µg of SB vaccine (Engerix-B) within 12 hrs of birth. The 2nd dose of vaccine is recommended at 1 mo of age and the 3rd dose at 6 mos of age.
- 2** Adolescents who have not previously received 3 doses of hepatitis B vaccine should initiate or complete the series at the 11-12 year-old visit. The 2nd dose should be administered at least 1 mo after the 1st dose, and the 3rd dose should be administered at least 4 mos after the 1st dose and at least 2 mos after the 2nd dose.
- 3** DTP4 may be administered at 12 mos of age, if at least 6 mos have elapsed since DTP3. DTaP (diphtheria and tetanus toxoids and acellular pertussis vaccine) is licensed for the 4th and/or 5th vaccine dose(s) for children aged  $\geq 15$  mos and may be preferred for these doses in this age group. Td (tetanus and diphtheria toxoids, adsorbed, for adult use) is recommended at 11-12 years of age if at least 5 years have elapsed since the last dose of DTP, DTaP, or DT.
- 4** Three *H. influenzae* type b (Hib) conjugate vaccines are licensed for infant use. If PRP-OMP (PedvaxHIB [Merck]) is administered at 2 and 4 mos of age, a dose at 6 mos is not required. After completing the primary series, any Hib conjugate vaccine may be used as a booster.
- 5** Oral poliovirus vaccine (OPV) is recommended for routine infant vaccination. Inactivated poliovirus vaccine (IPV) is recommended for persons with a congenital or acquired immune deficiency disease or an altered immune status as a result of disease or immunosuppressive therapy, as well as their household contacts, and is an acceptable alternative for other persons. The primary 3-dose series for IPV should be given with a minimum interval of 4 wks between the 1st and 2nd doses and 6 mos between the 2nd and 3rd doses.
- 6** The 2nd dose of MMR is routinely recommended at 4-6 yrs of age or at 11-12 yrs of age, but may be administered at any visit, provided at least 1 mo has elapsed since receipt of the 1st dose.
- 7** Varicella zoster virus vaccine (Var) can be administered to susceptible children any time after 12 months of age. Unvaccinated children who lack a reliable history of chickenpox should be vaccinated at the 11-12 year-old visit.

## FACT SHEET FOR MEDICAL MANAGED CARE CONTRACT HEALTH PLANS ON COMMUNITY-WIDE IMMUNIZATION REGISTRIES

Immunization Branch, California Department of Health Services (DHS), September 6, 1996

**Purposes:** To maintain merged, complete, up-to-date immunization records of at least all preschool-age children in the community who are immunized by public and private sector medical care providers who elect to participate in the registry. To use this information to (a) provide a child's immunization history to a requesting immunization provider virtually immediately upon request; (b) to determine what immunizations are currently due for that child for the provider, if he/she requests this; (c) to issue immunization reminder or recall notifications to families urging them to take their child back to their provider for the next dose (unless the provider wishes to issue these notifications himself/herself); (d) to supply providers with reports on immunization coverage of their clientele.

**Development and System Architecture:** Development of immunization registries in California is occurring "from the bottom up." That is, as of mid-1996 approximately 20 county and city health departments have begun to construct registries. These will be electronically networked together by DHS for purposes of transferring immunization histories of patients who move from one local registry jurisdiction to another. As they progress through the development and implementation stages, local health departments will be approaching private medical sector immunization providers, including health care plans, inviting them to join the registry and providing them with training and other assistance in doing so.

**Benefits of Participation for Immunization Providers:** The basic benefits are those listed under "Purposes," above. In particular, providers will benefit from being able to immediately query the registry and obtain immunization records of new patients who arrive in their offices with no records in hand. One large HMO has already noted reduced vaccine procurement costs because of fewer duplicate immunizations given due to unavailability of patients' prior records. Other potential benefits include reduced missed appointments by patients as a result of immunization reminder notifications issued to families, less record keeping, less calling/writing to other medical care providers' to obtain patients' immunization records, and facilitation of clientele immunization coverage assessments (such as those needed for HEDIS).

**Confidentiality and Security Issues:** Recently enacted legislation (Health and Safety Code 3396) allows immunization providers to share specific patient medical record information (a set of patient identifying data elements and immunization histories, and nothing else) with immunization registries operated by local health departments without having to obtain from patients and retain signed authorizations for transfer of medical records. The registries must keep this information confidential and may share this information only with local immunization registries and immunization providers who request it. The latter may use this information only for purposes of providing immunization services to patients they see. Further, immunization providers can only request information on specific patients whom they identify; they cannot "browse" through patient records in the registry.

**Data Entry:** A key barrier for immunization providers who want to participate in registries is lack of staff to do the necessary data entry. To minimize this problem, registries are working with providers to take advantage of whatever existing computerized patient information is already kept (e.g., billing records) in order to avoid having to re-key enter information. Registries are also working to accommodate the varied computer hardware and software that providers may already be using.

**Health Plans Covering Multiple Local Jurisdictions:** DHS is working to develop standard telecommunications mechanisms for these plans to participate in the registry network without having to create separate linkages with each local registry where their immunization providers reside.

**Questions, Requests for More Information:** Call Ayesha Gill, Ph.D., DHS, (510) 540-3452.